State of Wisconsin
2005 - 2006 LEGISLATURE

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2005 SENATE BILL 128

March 18, 2005 - Introduced by Senators HANSEN, MILLER, RISSER, STEPP, WIRCH and HARSDORF, cosponsored by Representatives LEHMAN, BENEDICT, BERCEAU, BLACK, GRIGSBY, KREIBICH, OTT, PARISI, POCAN, POPE-ROBERTS, SHILLING, SEIDEL, SHERIDAN and ZEPNICK. Referred to Committee on Agriculture and Insurance.

AN ACT ***to amend*** 632.89 (2) (b) 1., 632.89 (2) (c) 2. b., 632.89 (2) (d) 2. and 632.89 (2) (dm) 2.; and ***to create*** 632.89 (1) (am) and 632.89 (2) (f) of the statutes; **relating to:** increasing the limits for insurance coverage of nervous or mental health disorders or alcoholism or other drug abuse problems.

Analysis by the Legislative Reference Bureau

Under current law, a group health insurance policy (called a "disability insurance policy" in the statutes) that provides coverage of any inpatient hospital services must cover those services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of the lesser of: 1) the expenses of 30 days of inpatient services; or 2) $7,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $6,300 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage of any outpatient hospital services, it must cover those services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of $2,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $1,800 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage of any inpatient or outpatient hospital services, it must cover the cost of transitional treatment arrangements (services, specified by rule by the commissioner of insurance, that are provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services) for the treatment of nervous and mental disorders and alcoholism and other drug abuse

problems in the minimum amount of $3,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $2,700 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage for both inpatient and outpatient hospital services, the total coverage for all types of treatment for nervous and mental disorders and alcoholism and other drug abuse problems need not exceed $7,000, or the equivalent benefits measured in services rendered, in a policy year.

This bill changes the minimum amount of coverage that must be provided for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems on the basis of the change in the consumer price index for medical services since the coverage amounts in current law were enacted. Inpatient services must be covered in the minimum amount of the lesser of: 1) the expenses of 30 days of inpatient services; or 2) $18,300 minus the applicable cost sharing or, if there is no cost sharing under the policy, $16,500 in equivalent benefits measured in services rendered. Outpatient services must be covered in the minimum amount of $3,100 minus the applicable cost sharing or, if there is no cost sharing under the policy, $2,800 in equivalent benefits measured in services rendered. Transitional treatment arrangements must be covered in the minimum amount of $4,700 minus the applicable cost sharing or, if there is no cost sharing under the policy, $4,200 in equivalent benefits measured in services rendered. The total coverage for all types of treatment for nervous and mental disorders and alcoholism and other drug abuse problems need not exceed $18,300, or the equivalent benefits measured in services rendered, in a policy year.

The table below provides information on treatment category, current minimum coverage amount, year of enactment, and the proposed coverage amounts based on

the increase in the federal cost–of–living for medical coverage "indexed" since the enactment of the current coverage amounts.

Treatment	*Current Minimum Coverage Amount*	*Year Enacted*	*Proposed Coverage Amounts*
Inpatient			
Cost–sharing	$7,000*	1985	$18,300*
No cost–sharing	$6,300	1985	$16,500
Outpatient			
Cost–sharing	$2,000*	1992	$ 3,100*
No cost–sharing	$1,800	1992	$ 2,800
Transitional			
Cost–sharing	$3,000*	1992	$ 4,700*
No cost–sharing	$2,700	1992	$ 4,200
All services	$7,000	1985	$18,300

*Minus cost–sharing

The bill also requires the Department of Health and Family Services to report annually to the governor and legislature on the change in coverage limits necessary to conform with the change in the federal consumer price index for medical costs.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 632.89 (1) (am) of the statutes is created to read:

632.89 **(1)** (am) "Consumer price index" means the consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor.

SECTION 2. 632.89 (2) (b) 1. of the statutes is amended to read:

632.89 **(2)** (b) 1. Except as provided in subd. 2., if a group or blanket disability insurance policy issued by an insurer provides coverage of inpatient hospital treatment or outpatient treatment or both, the policy shall provide coverage in every policy year as provided in pars. (c) to (dm), as appropriate, except that the total

coverage under the policy for a policy year need not exceed ~~$7,000~~ $18,300 or the equivalent benefits measured in services rendered.

SECTION 3. 632.89 (2) (c) 2. b. of the statutes is amended to read:

632.89 **(2)** (c) 2. b. ~~Seven thousand~~ Eighteen thousand three hundred dollars minus any applicable cost sharing at the level charged under the policy for inpatient hospital services or the equivalent benefits measured in services rendered or, if the policy does not use cost sharing, ~~$6,300~~ $16,500 in equivalent benefits measured in services rendered.

SECTION 4. 632.89 (2) (d) 2. of the statutes is amended to read:

632.89 **(2)** (d) 2. Except as provided in par. (b), a policy under subd. 1. shall provide coverage in every policy year for not less than ~~$2,000~~ $3,100 minus any applicable cost sharing at the level charged under the policy for outpatient services or the equivalent benefits measured in services rendered or, if the policy does not use cost sharing, ~~$1,800~~ $2,800 in equivalent benefits measured in services rendered.

SECTION 5. 632.89 (2) (dm) 2. of the statutes is amended to read:

632.89 **(2)** (dm) 2. Except as provided in par. (b), a policy under subd. 1. shall provide coverage in every policy year for not less than ~~$3,000~~ $4,700 minus any applicable cost sharing at the level charged under the policy for transitional treatment arrangements or the equivalent benefits measured in services rendered or, if the policy does not use cost sharing, ~~$2,700~~ $4,200 in equivalent benefits measured in services rendered.

SECTION 6. 632.89 (2) (f) of the statutes is created to read:

632.89 **(2)** (f) *Report on coverage limits.* The department of health and family services shall report annually to the governor and the legislature on revising the

coverage limits specified in this subsection based on the change in the consumer price index for medical costs.

SECTION 7. Initial applicability.

(1) This act first applies to a policy issued, renewed, or modified on the first day of the 13th month beginning after publication.

(END)